NEW PATIENT REFERRAL FORM

50 Business Parkway, Suite A, Richardson, TX 75081
(P) 972-666-0786 (F) 972-666-0532
Email: info@vitalphysicianhousecalls.com

Patient Name *(LAST)*:_____ *(FIRST)*:_____ *(MI)*:_____

Address:_____ **APT/BLDG#**: _____

City:_____ **State**:_____ **Zip**:_____ - _____

❑HOME ❑ APARTMENT ❑ DOMICILIARY **Name of Facility/APT**: _____

Patient Phone:_____ **Is this number to call when making Appointments**: ❑ YES ❑ NO

Patient Email : _____

SSN:_____ **Date of Birth** :_____ **Gender**: ❑MALE ❑ FEMALE

Marital Status :❑ SINGLE ❑MARRIED ❑WIDOWED ❑DIVORCED **Name of Spouse**: _____

In the event of an emergency : _____

Relation to patient:_____ **Phone**: _____

Does the patient have a POA/Guardian: ❑ YES ❑ NO *(Skip this Section)* **Legal Status**: ❑POA ❑ Guardian

Name:_____ **Relationship**: _____

Address: _____ **APT/BLDG#**: _____

City:_____ **STATE**:_____ **ZIP**:_____ - _____

POA/Guardian Phone:_____ **Notify before each visit**: ❑YES ❑ NO

Patient Diagnosis / Health Issues: _____

Special visit instructions: _____

Is the patient latex sensitive: ❑ YES ❑ NO **Is the patient currently being treated by a primary physician** ❑ *YES* ❑ *NO*

Is the patient currently on or receiving: ❑Hospice ❑Home Care ❑Aide Services ❑ **Other:** _____

Name of agency providing services:_____ **Phone**: _____

How did the patient heard about our services: ❑ Word of mouth ❑ HHA ❑ AFC/ALF ❑ MARKETING ❑ OTHER

Referring Party:_____ **PHONE**: _____

Medicare:_____ **Effective Date:**_____ **HMO Involvement:** ❑ *YES* ❑ *NO*

Part B eligible: ❑ *YES* ❑ *NO* **Open MSP**: ❑ *YES* ❑ *NO* **Verification**: ❑ C-SNAP ❑ PHONE

Medicaid *(IF APPLICABLE)*:_____ **Effective Date:**_____ **HMO Involvement:** ❑ *YES* ❑ *NO*

Other Insurance carrier *(IF APPLICABLE)*: _____

Policy Number:_____ **Group Number**: _____

Type of policy: ❑ HMO ❑ PPO ❑ TRADITIONAL ❑ PFFS **Phone**: _____